allied academies

International Conference on
Internal Medicine & Practice and Primary Care
&
International Meeting on
Breast Pathology & Cancer Diagnosis

April 04-05, 2018 | Miami, USA

Improving medication reconciliation in Robert Packer Hospital: A quality improvement project

Asish Regmi
Guthrie Robert Packer Hospital, USA

Introduction: Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking —including drug name, dosage, frequency, and route— and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition. The average hospitalized patient is subject to at least one medication error per day. More than 40 percent of medication errors are believed to result from inadequate reconciliation in handoffs during admission, transfer, and discharge of patients. Of these errors, about 20 percent are believed to result in harm. Many of these errors would be averted if medication reconciliation processes were in place.

Methods: During the project period which extended from September to October 2017, 106 patient charts were reviewed. Fifty patient charts were reviewed during pre-intervention period and 56 patient charts were reviewed during intervention period. Preintervention period was until September 18 and intervention period started after that. Only the patient admitted to two floors 6NW and 7M with eight or more medication were included. Medication reconciliation done during the admission and discharge were reviewed. Then intervention was done by educating residents and nurses about the project and differed ways available for doing the medication reconciliation. The charts of the patient admitted after my interventions were also reviewed for medication reconciliation error.

Results: Of the 50-patients enrolled in pre-intervention period 35 patient had incomplete medication reconciliation. Discrepancies were present on 30 patient's medication reconciliations. Most of the discrepancies were for dosing. Other discrepancies included duplicate medication, old medication not removed and important medication not resumed during admission. During post intervention of 56 patients, 18 patient's chart had incomplete medication reconciliation and discrepancies were present on 8 patient's charts.

Conclusion: Error and discrepancy do occur during medication reconciliation. Mostly occurs during transfer to floor from ICU or ER and on those patients who has multiple medications. Other discrepancies occur during admission from nursing home or discharge to the nursing home. It is impossible to eliminate medication reconciliation error, but some steps can be taken to reduce it. Change in EMR to be more user friendly, educating staff, patient and relatives and an appointment of medication historian whose job will be medication reconciliation of the patient who comes to the hospital.

Speaker Biography

Asish Regmi completed his medical school from Kathmandu medical college in the year 2017.after that he started working as medical officer in Kathmandu region for almost 4 years. Then he came to USA for his residency in the 2016 and is now 2nd year medical resident in Guthrie/ Robert Packer hospital.

e: asish.regmi@guthrie.org

Notes: